# USAID Community Care Program
# (USAID Programa de Cuidados Comunitários)
# Task Order No. GHH-I-05-07-00043-00

## # Quarter Report: Q 1 of Yr 4, October - December 2013 (Q 13)

**Date of Submission: 31 January 2014**

## TABLE OF CONTENTS

**List of Acronyms** *indicates the Portuguese acronym here rendered in English

| | |
|---|---|
| AIDS | Acquired Immune Depressant Syndrome |
| ANEMO* | Mozambique National Nurses Association |
| ART | Anti-Retroviral therapy |
| ARV | Anti-Retroviral |
| BOM* | Banco Oportunidade de Mozambique |
| CAP | Capable Partners Project |
| CCP | Community Care Program |
| CDC | Centers For Disease Control and Prevention |
| CHASS-Niassa | Clinical HIV AIDS Systems Strengthening Project – Niassa |
| CHASS-SMT | Clinical HIV AIDS Systems Strengthening Project – Sofala, Manica, Tete |
| CSO | Civil Society Organization (same as CBO, Community Based Organization) |
| DNAM* | National Directorate of Medical Assistance |
| DPMAS* | Provincial Directorate of Women and Social Action |
| DPS* | Provincial Directorate of Health |
| DQA | Data Quality Assessment |
| FANTA | Food and Nutrition Technical Assistance |
| FHI 360 | Family Health International |
| GAAC* | Community Adherence Support Group |
| GAVV* | Office of Violence Against Women |
| GRM | Government of the Republic of Mozambique |
| HIV | Human Immunodeficiency Virus |
| HBC | Home Based Care |
| HU | Health Unit |
| INAS* | Nacional Institute of Social Action |
| M2M | Mother to Mother groups |
| M&E | Monitoring and Evaluation |
| MISAU* | Ministry of Health |
| MMAS* | Ministry of Women and Social Action |
| MoU | Memorandum of Understanding |
| MUAC | Middle Upper Arm Circumference |
| NGO | Non Governmental Organization |
| NPCS* | Provincial Nucleo to Fight AIDS |
| OVC | Orphans and Vulnerable Children |
| PH | Project HOPE |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission (of HIV) |
| PNAC* | National Action Plan for Children |
| PPP | Public Private Partnership |
| PPPW | Pre and/or Post-Partum Women |
| PSI | Population Services International |
| PSS | Psychosocial Support |

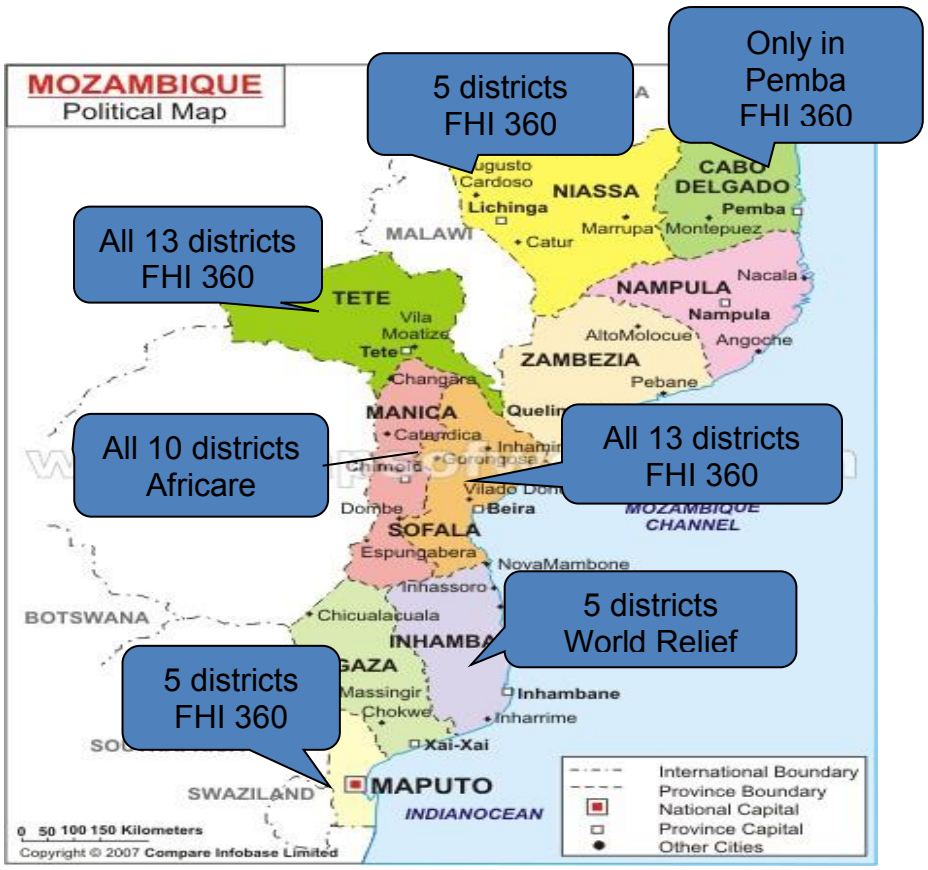
| | |
|---|---|
| RMAS* | Department for Women and Social Action |
| ROADs | Regional Outreach Addressing AIDS through Development Strategies (ROADS) |
| SDSMAS* | District Services of Health, and Women and Social Action |
| TA | Technical Assistance |
| TB CARE | TB Project Care |
| ToT | Training of Trainers |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VS&L | Village Savings and Loan (groups) |
| WR | World Relief International |

1. **Project Duration: (5)** Five years

2. **Starting Date:** September 2010

3. **Life of project funding:** September 2010 – September 2015

4. **Geographic Focus**: Maputo, Inhambane, Sofala, Manica, Tete, Cabo-Delgado and Niassa Provinces, 52 districts the per map.




5. **Program/Project Results (Objectives)**

USAID/Mozambique's Community Care Program (CCP), also known as Programa de Cuidados Comunitários (PCC) in Portuguese, is designed to strengthen the community-based response to HIV/AIDS in seven provinces and improve the health and quality of life of people living with HIV (PLHIV), orphans and vulnerable children (OVC), and pre- or post-partum women. Working in close partnership with civil society organizations (CSOs), the Ministry of Health (MoH, or MISAU in Portuguese), the Ministry of Women and Social Action

(MMAS in Portuguese), and the private sector, CCP will also strengthen the government's capacity to coordinate, manage, and oversee an integrated continuum of care and support and will build the CSOs' capacity to provide comprehensive, community-based care and support services. Within five years, CCP will achieve for PLHIV, pre- or post-partum women, OVC and their families: increased provision of family-centered, community-based HIV care and support services, and increased access to economic strengthening activities and resources for HIV-affected households.

The CCP results (objectives) are:

1) Increased provision of quality, comprehensive, community-based care and support services to people living with HIV and AIDS and their families.
2) Increased family-centered, community-based services that improve health outcomes and quality of life for PLHIV, OVC, and pre/post-partum women and that are implemented by the coordinated efforts of the Ministry of Women and Social Action (MMAS), the Ministry of Health (MISAU), and civil society organizations (CSOs).
3) Increased numbers of HIV/AIDS positive individuals and affected households have adequate assets to absorb the shocks brought on by chronic illness.

CCP also applies six cross-cutting strategies to ensure the sustainability of project results, including: 1) community-driven approaches; 2) services integration; 3) capacity building and systems strengthening; 4) partnership and coordination; 5) performance improvement; and 6) gender-sensitive and age-appropriate interventions.

## 6. Summary of the reporting period, Q1 Yr 4

This first quarter of Year 4 was perhaps the most challenging for CCP to date, characterized by various uncertainties which will be detailed in this progress report. CCP as a project is reaching stunning maturity where it is working very well. The holistic approach, the integrated services vision, the marrying of HES with community based HIV services, the capacity building of all levels concerned, are all programming ideals worth the effort. These very hallmarks of CCP are also the factors that translate to things taking time to become their most effective. Here follows excerpts from one of the Success Stories attached, entitled "Adherence and PMTCT make a powerful combination!" The subject of this story, Gracinda Samusson, embodies several of the CCP components.

*"It is like a miracle, my baby was born HIV-free"*

Gracinda living in Cuamba district in Niassa Province, got very sick in 2009 and had no one to care for her; her husband abandoned her when she fell ill. Her situation started to change in 2012 when an *activista* of Hankoni[1] visited her and counseled her to go for voluntary HIV testing, given her condition. Gracinda found she was HIV+. From that day forward, she became part of the Hankoni family and followed her treatment rigorously, followed nutritional guidance, gave herself time to rest, and lived a positive life. **Gracinda was a model for adherence,** her health improving enough to regain her life, and she even became an *activista*.

[1] HANKONI, a local CSO implementing CCP.

Her husband returned when she had improved and after hearing all she had experienced, went for testing and learned he also was HIV+.

*"My husband never hesitated to get tested because he was so moved by the changes he saw in me, his wife,"* Gracinda.

Gracinda and her husband are both on ART and adhering well. She got pregnant under good care and counseling from the health unit PMTCT team, and this couple was blessed with a baby who is in good health and HIV free. They have since been highly involved in community mobilization for HIV counseling, testing, support and adherence, and seeking health services.

*"It is possible to live with HIV and live a healthy life, only if one is willing to follow all the recommendations and instructions from the health professionals. An HIV-Free Generation is possible, my baby is HIV-free,"* says Gracinda.

**Year 4** will see stronger efforts to match the mandated emphasis areas for CCP. These include:
Identifying and referring <u>all</u> pre- and post-partum women in the CSO catchment area to **PMTCT**
Supporting all OVC caregivers to join **VS&L groups**
Assuring all CCP enrollees are **tested** for HIV, especially all children
Strengthening **adherence** within the integrated caregiving model
Providing **Parenting Skills** guidance to OVC parents and guardians
Improving **referrals and counter-referrals** to and from clinical services with a rotating *activista* plan

CCP continues to face the challenges of unpredictable insecurity in some implementation areas, discontinuous funding, long drawn out approval processes, low capacity in some areas, high expectations overall. Complementing the challenges are high commitment from project team at all levels, strides made in knowledge and creating "synergies" across project components, and the results of thousands of peoples' lives improving with this PEPFAR funded project.

## 7. Project Performance Indicators for Q1 Yr 4

| *Indicator* | *Annual Target #* | *Q1 Yr4 Results* | *% Achieved Q1Yr4* | *Q2 Results* | *% Achieved Q2* | *Q3 Results* | *% Achieved Q3* | *Q4 Results* | *% Achieved Q4* | *Y4 Results* | *% Achieved in Y4* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *# of new HBC clients* | *23,760* | *3,577* | *15%* | | | | | | | | |
| *Cumulative # HBC clients* | | *17,304* | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *receiving care* | | | | | | | | | | | |
| *# of New OVC served* | *79,950* | *12,508* | *16%* | | | | | | | | |
| *Cumulative # OVC served (APR)* | | *71,837* | | | | | | | | | |
| *# pre/post-partum women referred to PMTCT* | *10,600* | *276* | *3%* | | | | | | | | |
| *# receiving nutrition services* | *45,000* | *13,865* | *31%* | | | | | | | | |
| *# participating in Kids' Clubs* | *12,000* | *3,501* | *29%* | | | | | | | | |
| *# referrals to MCH (general) HIV (CT), Social Services* | *39,300* | *4,365* | *12%* | | | | | | | | |
| *# referrals to MCH* | | *1,267* | | | | | | | | | |
| *# referrals to HIV (CT)* | | *1,638* | | | | | | | | | |
| *Referrals to Social services* | | *1,460* | | | | | | | | | |
| *# referrals to TB, Malaria and CCR* | *6,580* | *1,483* | *23%* | | | | | | | | |
| *referrals to TB* | | *447* | | | | | | | | | |
| *# referrals to Malaria* | | *783* | | | | | | | | | |
| *# referrals to CCR* | | *253* | | | | | | | | | |
| *# of OVC 15-17 y.o. referred to family planning* | *1,500* | *513* | *34%* | | | | | | | | |
| *% HIV defaulters on list returned to ART/clinic* | *60%* | | *50%** | | | | | | | | |
| *# of pregnant women referred suspected malnutrition* | | *97* | | | | | | | | | |
| *# of children referred suspected malnutrition* | | *185* | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *# VS&L groups formed* | *276* | *75* | *27%* | | | | | | | | | |
| *VS&L groups members by gender* | *70% of all members female* | | *78%* | | | | | | | | | |

***Important note to the table: CCP achieved 87% treatment defaulters returned to treatment, of those found from the lists. See Table 9.***

**Detailed** write-ups follow in specific activity areas of this report, per Result. Brief (bullet only) comments are offered here. Leading off,

- Low **new** HBC results reflect an unforeseen transition period per definition used for HBC reporting. True *activista* HBC current case load, (service delivery), is reflected in the cumulative 17,304.
- Low **new** OVC results reflect back to the enormous true OVC case load, 79,950, of combined Intensive and Maintenance phase services.
- Very low referrals to PMTCT may reveal a reporting variance between known HIV+ referrals and the 3,818 PPPW who received CCP services.
- Nutritional services continue to be very successfully delivered, also considering seasonal and INAS factors.
- Kids Clubs participation is above quarter target, due in part to school holidays and stepped up TA to create new clubs.
- Aggregate referrals to TB, Malaria, and CCR are close to target; disaggregation shows where to give more effort.
- CCP experienced astounding turn-around in the service area, due to revised strategy and approach.
- New VS&L groups slightly exceeded the quarter target.

**Result 1:** Increased provision of quality, comprehensive, community-based care and support services to people living with HIV and AIDS and their families.

**Activity Area 1.1:** Training and capacity building of CSOs and providers in community-based care and support

***Table 1: Q1 – Yr 4 Selected Trainings and Refresher Trainings by area, gender***

| Province | TOT Child Protection | | ToT Gender | | M&E | | Accreditations | | Supervision | | Economic Strengthening | | Reproductive Health-PF | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| **Maputo** | - | - | - | - | - | - | - | - | - | - | - | - | 45 | 35 |
| **Inhambane** | - | - | - | - | - | - | - | - | 6 | 4 | - | - | - | - |
| **Sofala** | - | - | - | - | 28 | 9 | 4 | 0 | - | - | - | - | - | - |
| **Tete** | 18 | 9 | 18 | 9 | - | - | - | - | - | - | - | - | - | - |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Niassa** | - | - | - | - | - | - | - | - | - | - | 15 | 05 | - | - |
| **Total Q4** | 27 | | 27 | | 37 | | 4 | | 10 | | 20 | | 80 | |

Trainings across CCP implementation areas are held for various purposes and according to local needs, TA recommendations, and various timing factors. Sometimes there are trainings that take place in all CCP districts simultaneously, as well as the other model based on the profiled needs just mentioned. ToT for Child Protection and Gender is conducted at the same time for four days, thus resulting in the same number of participants for each area. This ToT in Chiúta included 20 *activistas*, the head of SDSMAS, the HIV/AIDS focal point, the Head Police Officer, one community leader, one School Principal (Mavuze Ponte), and the CSO Coordinator and Program Officer. This ToT was facilitated by CCP Maputo Technical Officers and represents a broad investment in the target community leaders for future benefit and continuity.

Training on M&E and DQA using a data verification tool (DVIT) was conducted in Beira, Sofala province, for the CSO M&E officers from 7 Sofala districts, provincial M&E technical officers from both Sofala and Manica (Africare) provinces who will provide continuous on-the-job training, supervision and support to the CSOs in DQA. FHI 360 Senior Technical Officers conducted the training, which included a hands-on practicum component doing DQA with six CSO partners across FHI projects, toward the objective of building skills and greater capacity for better data quality and reporting. DPS-Sofala and, CEDES were also included, to build capacity with GRM and other key stakeholders beyond the structure of the project.

ANEMO carried out its accreditation process for four nurses, from Dondo (2), Gorongosa (1) and Muanza (1) districts, continuing to fulfill the CCP mission of building local resources of accredited trainers who in turn train the *activistas*.

Project HOPE held a VS&L Group Facilitators training in Lichinga, Niassa province, which also included the CCP technical officer there to facilitate good coordination and cross-support. Consistent with CCP practice, two SDAE technicians were included, to assure investing in broader community structures for future viability. The training had the following objectives:

- Train and integrate new Group Facilitators
- Refresher for facilitators that were already working in the program
- Integration and clarify the role of facilitators and linkages across project implementation areas
- Strengthening the referral component and selection of target group for VS&L groups, through increased *activistas'* 1) attention to referring all CCP beneficiary households and 2) stepping up M2M and GAAC groups member referrals as well.

In Manica Province, refresher training on the CCP integrated care approach and using the referral tool and system was held for supervisors and *activistas* of the CSOs Rubatano in Gondola, Shinguirirai in Chimoio, ANDA in Manica, and Centro Aberto in Barué. received this attention to improve their performance.

The Supportive Supervision ToT held in Maputo last quarter for FHI and WR Technical Officers was cascaded to the Coordinators and Supervisors from all five Inhambane province CCP implementing CSOs. Topics included supervisory Roles and Responsibilities and using standard tools such as Workplans and a Supervision Guide. The recipients benefited greatly from this training, since it is often the case that people in such positions have no real prior training and simply learn as they go. To have such skills is important for all those who are

entrusted with managing human resources, community beneficiaries, and aim to provide quality services.

## Organizational Capacity Building

As reported last quarter, the subcontract relationship was finally established with ADEM, to carry out the organizational capacity building of the rest of the CSOs not covered under the partnership with the CAP project. The ensuing ADEM assessments took place in Niassa, Cabo Delgado and Inhambane provinces. Those assessments have now been processed into capacity building plans for the assessed CSOs and trainings mapped out to commence next quarter.

***Table 2: Organizational Capacity Building assessment Provinces and districts***

| PROVINCE | DISTRICT | CSO | CSO Location |
|---|---|---|---|
| NIASSA | MANDIMBA | IRMÃOS UNIDOS | MANDIMBA |
| | MECANHELAS E ENTRELAGOS | ACS – AGENTE COMUNITÁRIO PARA SAÚDE | MECANHELAS |
| | CUAMBA | HANKONE E YOLAKA | CUAMBA |
| | METARICA | WUPUELA | METARIKA |
| | NGAUMA | TRILHO JUVENIL | NGAÚMA |
| CABO DELEGADO | PEMBA | ASSOCIAÇÃO KAÉRIA | PEMBA |
| INHAMBANE | MAXIXE | ASSOCIAÇÃO LIWONINGO | MAXIXE |
| | INHARRIME | REDE PASTORAL DE INHARRIME | INHARRIME |
| | HOMOINE | REDE PASTORAL DE HOMOINE | HOMOINE |
| | INHAMBANE | ASSOCIAÇÃO UTOMI | INHAMBANE |
| | MORRUMBENE | REDE PASTORAL DE MORRUMBENE | MORRUMBENE |

For example, the Niassa assessments involved the CSO Boards of Directors, and Board Members, during which a weakness associated with any of the capacity areas can be observed. Those areas include Associativism, Governance, Leadership & Management, Policy & Procedures, and Internal Controls.

In Tete province, the ADEM executive director himself presented their project component to the CCP team and all CSO Coordinators. Given the vastness, and seasonal transport and farming challenges, at this meeting everyone involved planned the Assessment calendar to best gather the various Boards and Directors at their locations.

The Assessment strategy is to use the resulting assessment as the basis for a participatory discussion to elaborate the training plan.

***Table 3: Quantitative CSO assessments participants, by type***

| Province | Total participants | Male | Female | Board of Directors | CSO Members | Executive CSO Staff |
|---|---|---|---|---|---|---|
| Inhambane | 26 | 10 | 16 | 13 | 7 | 6 |
| Niassa | 22 | 7 | 15 | 10 | 5 | 7 |
| Cabo Delegado | 12 | 3 | 9 | 4 | 3 | 5 |
| **Total** | **60** | **20** | **40** | **27** | **15** | **18** |

As well, the second phase of Organizational Capacity Building activities with CAP have started, with the solicitation of manifestation of interest to ACIDECO, CONFHIC, Kugarissica and Centro Aberto de Barué (CA). Based on the response to this solicitation, CAP undertook sites visits and conducted financial health checks to these CSOs. As a result ACIDECO, CONFHIC and Kugarissica are ready to initiate the second phase of capacity building, and CAP is currently awaiting a response from CA. CAP also proposes to include Rubatano and Chinguirirai because these CSOs attained good results in the first phase. Unfortunately, two others who were good candidates for moving forward under the CAP methodology were excluded due to military political instability in their areas.

**Support and Technical Assistance visits to CSOs**

In Tete province eight technical assistance (TA) visits – some joint with CHASS SMT - were conducted to strengthen program management, M&E, community mobilization and other technical areas. Technical staff also made home visits to beneficiaries, provided on-the-job refresher training to the *activistas* and CSO supervisors on procedures and implementation of Minimum Packages of Services for OVCs, PLHIV and PPPW in Angónia, Changara, Chifunde, Chiúta, Cidade de Tete, Mágoè, Marávia and Moatize districts. These TA visits resulted variously in a joint action plan to strengthen referrals, creation of 45 Kids clubs, creation of 7 M2M groups, CSO data base cleaning, and improved CSO reporting, which in turn allowed an on-time quarterly report submission from Tete province.

CSO site visits also included coordination meetings with Health Units, clinical staff, case managers, lay counselors for voluntary community testing (VCT), ADELT and TB staff, to support and emphasize the linkage relationships and information exchange across projects to best assure referrals and collaboration. The HU meetings were used to introduce and advocate for placing a CSO *activista* in the HU on a rotating basis with the *Gestor do Caso* to improve referrals, and especially counter-referrals by the clinics to community services when needed.

In Sofala province, due to security limitations and unpredictability, there were just four TA visits conducted in Dondo, Muanza, and Cheringoma districts and Beira City. These included on-the-job (OJT) refresher trainings for the CSOs *activistas* and Supervisors on using the referral tool. In addition, the Supervisors received OJT on reviewing and analyzing *activistas'* data collection for M&E.

In Niassa province, TA visits took place in all five project implementation districts, each according to implementation or performance needs. Example TA activities included strengthening existing Kids Clubs and CCPCs, creating additional Kids Clubs, supporting CSO hiring, M&E orientation, strengthening CCPCs, and routine financial management support. Project HOPE also provided TA in Cuamba, Mecanhelas and Metarica districts to strengthen the VS&L groups, to establish new VS&L groups, and providing support on using the monitoring forms.

In Maputo Province, the CSOs benefitted from 16 TA visits. During these visits OJT training activities included: verification of files where M&E forms are kept and support on monthly report compilation. This approach allowed the technical officers to have on-on-one contact with the *activistas*. In Matutuine, Moamba, Manhiça and Marracuene districts support was provided to create M2M groups and CCPCs, strengthen the Kids Clubs, do cooking demonstrations, and also mentoring on financial and sub-agreements management.

In Cabo Delgado three TA visits' main objectives were to conduct on-the-job refresher trainings to the Kaeria *activistas* and staff on the CCP integrated approach and the emphasis areas for Year 4. These include the need to increase the maintaining the OVC Minimum Package and to support the VS&L groups to create a social funds to support community OVC. Meetings were also held with the Health Units and ARIEL to improve the referral system and make gains in the areas of Counseling and Testing, PMTCT, children at risk (CCR), and malnutrition.

In Manica province, the majority of TA visits were carried out jointly between the FHI 360 projects - CCP and CHASS SMT. This is a preferred visit model and improves mutual understanding of the referral and counter-referral system, and the loss-to-follow-up process. This visit model also helps to clarify the roles of the clinic-based *Gestores dos Casos* and the CSOs-based *activistas*. Both projects' Community Mobilization Officers further expanded the visit team to include SDSMAS, and HU staff, to provide continuous technical support to the CSOs' *activistas.* M&E TA in Gondola, Manica, and Cidade de Chimoio districts had the following objectives.

- Verification of the data collection system
- Data quality anaysis
- Filing management
- Report compilation covering both the quantitative and qualitative components

The joint visit model was also employed in Tete. These joint visits involved meetings with clinical staff in HU, with participating case managers and lay counselors, to:

- Explain and review the referral/counter-referral system and tool
- Cover lost-to-follow up process
- Make a calendar and topics for the Co-Gestão committees
- Include pre-ART, PMTCT and CCR in the follow up lists
- Collect, count and fill in for report writing on referrals
- Clarify on the roles and responsibilities of case managers and *activistas*
- Discuss placement of an *activista* in the HU on a rotational basis to provide support in the process of referrals, family-based counseling and lost to follow up.

Both of these activities also strengthened the linkages between the FHI 360 projects (CHASS SMT and CCP) at the implementation level, where the *activistas* of both projects can coordinate their plans for referral practices and lost-to-follow up.

It merits mentioning that the Manica province Africare team is working hard to address various M&E challenges and gaps they face. At the same time, this served as OTJ training for the Africare M&E Officer to improve his technical and mentoring skills to better support the CSOs of Manica province. CCP actively builds capacity at all levels possible within the project framework.

In Inhambane province, TA focused on strengthening and improving the quality of monthly reports compilation, compliance with the Minimum Standards of Services to OVC, PLHIV and PPPW, as well as ensuring that CCP beneficiaries are referred to health and social services and integrated into the VS&L groups. It was also an opportunity to hold coordination meetings with SDAE, where CCP beneficiaries are referred for agricultural activities support, and SDSMAS, to continue to strengthen the referral system and improve the loss-to-follow-up process.

**Activity Area 1.2:** Strengthen the provision of comprehensive services at community level for PLHIV, OVC and Pre- and Post-partum women and their families

In spite of persistent challenges in some implementation sites, generally the referrals in this reporting period have improved significantly as a result of continuous coordination meetings with MISAU, DPS, SDSMAS, Health Unit technicians and clinicians, other implementing partners and joint site visits. Challenges include continuous high rotation of HU technicians who have been trained in the use of the referral tool, and the long wait for MISAU official approval of the referral tool for institutionalization.[2] The former leads to a type of stop and go progression, where referrals might be going well, only to be interrupted by the need to retrain new staff people to regain lost ground.

Another factor which has contributed negatively to the referral results and process during this reporting period is the political-military tension in parts of the country leading up to and following the elections in November. Some beneficiaries who were referred could not show up to their

[2] CCP learned that MISAU had finally approved the *Guia de Referencia* (referral tool) in January 2014, however, it lacked the force that we had all been waiting for. There was no instruction in the approval for provincial structures to roll it out in all their facilities. CCP is following up with MISAU proponents to gain that intended strength to the approval.

Health Unit for ART or other specialized health services without fear of being under cross fire. See second Annex for a cursory compilation of areas affected by violence during this period. In addition, some beneficiaries went to their far away farms for seasonal agricultural activities, the basis of sustenance for many.

An earlier challenge that CCP has overcome during this quarter is referring 15-17 year olds to family planning. *Activistas* and supervisors took a much more "family" approach to counseling, sensitization and referrals of youth in this age group, and have produced positive results, to the point that CCP across provinces registered 513 total youth referred to family planning. This represents a 34% achievement against a 25% expectation, per summary Project Performance Indicators on page 7 of report. This figure does not include 80 youth from Manhiça district that participated in a local training on sexual reproductive health and were then referred to a family planning consultation. They are not included because technically the referral tool was not the mechanism, but rather the nurse who conducted the training.

Referrals for the consultation of children at risk (CCR) have increased, because the mothers more often now take their children to their post-partum consultation. CCP has improved on referrals for voluntary testing (1,638) and for those suspected of malaria (783).

In this reporting period, the cases disclosing sexual abuse to the GAVV have increased, 204. CCP does not believe that sexual abuse is on the rise, but rather that the environment for disclosing and seeking support has improved. For example in Marracuene district, the number of reported child sexual abuse cases drew special attention which led to a meeting involving CCPC members, Social Action technicians from SDSMAS, the GAVV and Police. This exemplifies another CCP contribution to broader community ownership of issues and citizens, beyond the framework of the project. Increasing reported cases also reflects increased sensitization and awareness across the communities, to enable bringing these things out into the open **with** confidence in supportive response, and **without** fear of stigma or a "blame the victim" attitude.

Counter-referrals from the HU to the CSOs community based services are another story. Some districts of Maputo and Manica provinces are showing an increase of referrals signed and made from the HU to the community for follow up on CCR, and PLHIV bedridden cases. In Manica 145 patients were referred from the HU for follow up in the community, in Tete 78 and Maputo 67. CCP is making progress on this front.

***Table 4: Q1-Yr 4 Total Completed Referrals by province, service referral area***

| | MCH Services (1,796) | | | | | | HIV Services (3,043) | | | | | | Social Services (1,460) | | | | | | Other Services (1,984) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Province | Maternity for birth | MCH | Family planning consultation | post birth Consultation | Consultation for children at Risk | PMTCT | CT | STI | Pre TARV/IO | HIV+ Test | LTFU TARV | PPE | Community/CSO | Education | Social Action | GAVV/Police post | Psychology/Psychiatrist | IPAJ | Children referred with suspect of malnutrition | Pregnant women referred with suspect of malnutrition | Emergency | Suspect of TB | Suspect of Malaria |
| Cabo Delgado | 19 | 40 | 41 | 26 | 37 | 45 | 32 | 18 | 34 | 36 | 35 | - | 21 | 30 | 28 | 6 | 14 | - | 29 | 32 | 41 | 21 | 57 |
| Inhambane | 8 | 72 | 84 | 19 | 17 | 31 | 159 | 28 | 28 | 62 | 32 | 10 | 20 | 53 | 39 | 28 | 14 | 11 | 17 | 11 | 118 | 64 | 150 |
| Manica | 84 | 73 | 134 | 68 | 90 | 77 | 258 | 51 | 38 | 54 | 205 | 12 | 145 | 67 | 76 | 43 | 1 | 1 | 29 | - | 115 | 162 | 269 |
| Maputo | 44 | 78 | 167 | 47 | 79 | 78 | 224 | 46 | 57 | 61 | 73 | 20 | 67 | 38 | 89 | 24 | 9 | 22 | 5 | 52 | 60 | 72 | 52 |
| Niassa | 4 | 12 | 9 | - | 2 | 1 | 74 | 16 | 8 | 31 | 42 | - | - | - | 34 | 2 | - | - | 4 | 2 | 11 | 11 | 62 |
| Sofala | - | 35 | 27 | 12 | 13 | 16 | 464 | 20 | 25 | 62 | 34 | 29 | 55 | 3 | 13 | 100 | 1 | 7 | 9 | - | 16 | 12 | 120 |
| Tete | 24 | 49 | 51 | 40 | 15 | 28 | 427 | 31 | 53 | 84 | 70 | - | 78 | 163 | 55 | 1 | 101 | 1 | 92 | - | 111 | 105 | 73 |
| **All totals** | **183** | **359** | **513** | **212** | **253** | **276** | **1,638** | **210** | **243** | **390** | **491** | **71** | **386** | **354** | **334** | **204** | **140** | **42** | **185** | **97** | **472** | **447** | **783** |

**Home Based Case**

CCP finds itself in a transition period now, as regards registration forms and definitions. The HBC client registration form used by CCP since inception is based on the MISAU form, which indicates HIV Stage 3 or 4 for enrollment. This usually means a PLHIV bedbound at least some portion of the time. CCP has always been reporting these numbers, thereby not including the many PLHIV on ART who are being followed for adherence. [Exceedingly relevant though not occurring exactly in this quarter, MISAU called a meeting in January 2014 to establish HBC indicators. The CCP Sr M&E Officer participated, and represented well the need to include HBC clients under adherence support. CCP has already undertaken making the changes to its HBC enrollment and data reporting procedures in order to accurately reflect the contribution to adherence and retention that community based service providers are already making. CSOs and their *activistas* are being retrained on using the standard MISAU form, to now indicate whether those HBC enrolled individuals are Stage 1 or 2, in addition to Stages 3 or 4 as originally used by CCP. Capturing the Stage 1 or 2 PLHIV gives us the contribution to adherence support that CCP was missing before. ]

Ironically given the political-military violence concentrated in Sofala province implementation areas, in this reporting period Sofala province nearly reached its new HBC client target. Tete, Cabo Delgado, Maputo and Inhambane provinces did not reach the 25% target. Not all provinces and implementing areas are the same by any means; some are in between large numbers of discharged HBC clients and identifying/enrolling new ones. Alternatively, many patients enrolled in the previous quarter were not discharged (or graduated) because they did not meet the graduation criteria yet, which logically leads to non-enrollment of new patients. Tete province reports its low performance this quarter is a combination of fewer Stage 3 or 4 PLHIV due to collaborative project interventions, seasonal agricultural activities where families take their "patient" family members with them to their farms, and some *activistas* drop outs. The cumulative HBC client service delivery of 17,304 reflects the more real HBC contribution, and at the same time is under-reported given the above.

***Table 5: Q1-Yr 4 Achievement in New HBC clients by province***

| Province | HBC Annual Target Yr 4 | Newly Enrolled in Q1 Yr 4 | % of Achievement Q1 Yr4 |
|---|---|---|---|
| Cabo Delgado | 456 | 55 | 12% |
| Inhambane | 2,285 | 301 | 13% |
| Manica | 4,569 | 685 | 15% |
| Maputo | 2,285 | 293 | 13% |
| Niassa | 2,285 | 400 | 18% |
| Sofala | 5,940 | 1381 | 23% |
| Tete | 5,940 | 462 | 8% |
| **TOTAL** | **23,760** | **3,577** | **15%** |

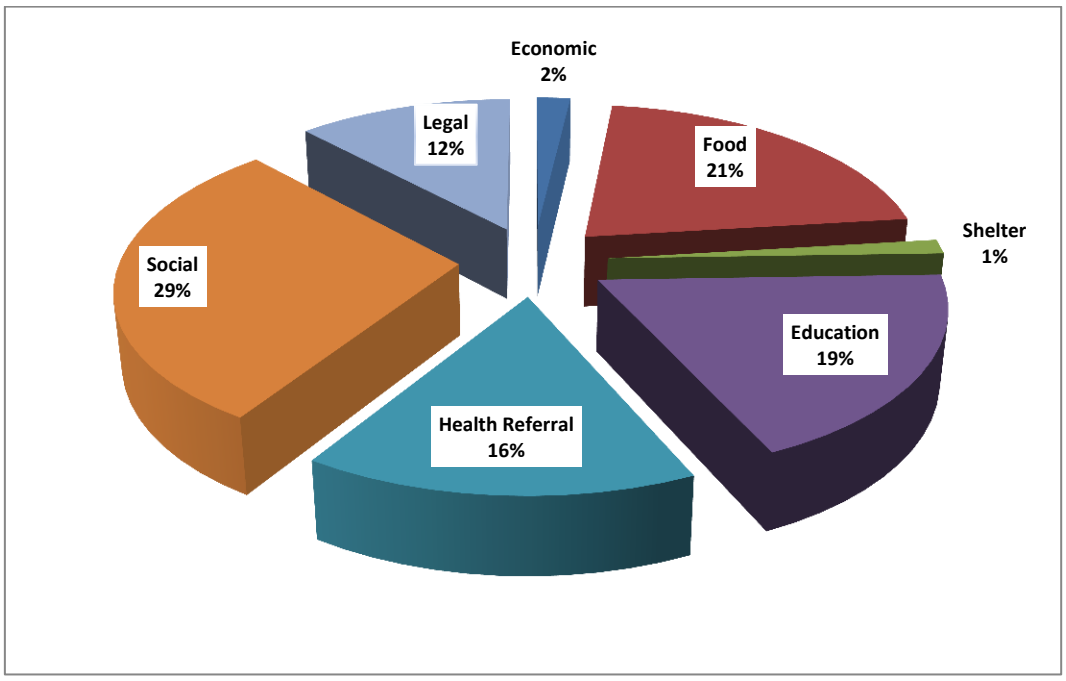
## Orphans and Vulnerable Children

The replacement CSOs selection and start up processes in Niassa province affected the performance in three districts in this reporting period, yielding only 633 new children, 8% of quarterly target. On the other hand in Manica province, 2,900 new children were enrolled. Generally, the enrolment of *new* children is reducing since with no OVC graduation, the *activistas* keep accumulating OVC enrollees and regardless of differentiating between Intensive and Maintenance phases, the case load is still massive. See the summary Project Performance Indicators on page 7 for cumulative OVC actively served during the quarter. As well, the *activistas* are active with CCPCs, Kid's Clubs, increasing administrative requirements, and adding on strengthening the loss to follow up on PMTCT, CCR components.

***Table 6: Q1-Yr 4 Newly Enrolled OVC by province***

| Province | OVC Annual Target for Yr 4 | Newly Enrolled in Q1 Yr4 | % of Achievement Q1Yr4 |
|---|---|---|---|
| Cabo Delgado | 1,533 | 253 | 17% |
| Inhambane | 7,688 | 1,338 | 17% |
| Manica | 15,375 | 2,900 | 19% |
| Maputo | 7,688 | 1,293 | 17% |
| Niassa | 7,690 | 633 | 8% |
| Sofala | 19,988 | 3,096 | 15% |
| Tete | 19,988 | 3,074 | 15% |
| **TOTAL** | **79,950** | **12,587** | **16%** |

***Chart 1: OVC Disaggregated Services Delivery Q1-Yr 4***



The chart above shows that psychosocial support continues to be a high service delivery area (29%), followed by food support (21%). This quarter has seen more availability of INAS sourced food baskets for referred cases. Education services (19%) reflected support especially for final school test and examination preparation, as well as school holidays.

***Table 7: Q1-Yr 4 OVC Services disaggregated by gender and service area***

| Province | OVC Target for Yr 4 | Male | Female | Economic | Food | Shelter | Education | Health Referral | Social | Legal |
|---|---|---|---|---|---|---|---|---|---|---|
| Cabo Delgado | 1,533 | 131 | 122 | 53 | 164 | 48 | 180 | 233 | 253 | 87 |
| Inhambane | 7,688 | 645 | 693 | 57 | 1,145 | 40 | 789 | 577 | 1,158 | 232 |
| Manica | 15,375 | 1,506 | 1,394 | 153 | 1,412 | 142 | 1,520 | 965 | 2,077 | 885 |
| Maputo | 7,688 | 606 | 687 | 171 | 803 | 100 | 662 | 464 | 736 | 361 |
| Niassa | 7,690 | 310 | 323 | 0 | 156 | 1 | 113 | 48 | 475 | 38 |
| Sofala | 19,988 | 1,572 | 1,524 | 52 | 1,214 | 15 | 1,161 | 1,225 | 2,168 | 738 |
| Tete | 19,988 | 1,524 | 1,550 | 84 | 1,627 | 89 | 1,344 | 1,320 | 1,979 | 1,343 |
| **TOTAL** | **79,950** | **6,294** | **6,293** | **570** | **6,521** | **435** | **5,769** | **4,832** | **8,846** | **3,684** |

*Note to the table: The total 12,587 will not match the total of services delivered (30,670) because children receive more than one service based on their needs assessment at enrollment.*

The table above shows an almost exact balance between male and female children receiving care and services (6,294 male and 6,293 female) in this reporting period. Additional education support this quarter included identifying school going age children not in school at present, establishing lists of them and submitting to their local schools for commencing enrollment in 2,014. We would expect then a further improvement in this service area next quarter as the referred children start school. CCP has adjusted its monitoring data to distinguish OVC caregivers as members of VS&L groups, 1,584 for this quarter (see Table 14), although we suspect that is still an underreported figure. Project HOPE and its HES implementing partners continue to give extra effort to this aspect to strengthen the reporting. An encouraging note is that the numbers of children receiving economic support (570) and house rehabilitation (435) are increasing which suggests VS&L group members using their pay-outs to improve the quality of life of their families; while some of these numbers may be through VS&L group social funds. Dispensation of Social Funds would be noted during close of Cycle, which will vary across all the seven CCP provinces according to when each VS&L group started and how long they determined their savings cycles to be.

Further to economic strengthening especially focused on OVC and youth, a group of 30 girls, aged 12-17 years old, was selected for "life skills" courses in Boane district, Maputo province. Training on carpet fabrication and sewing baby clothes was provided by Radio Marcon, which also linked the girls' products to local markets. The girls targeted their earnings for school uniforms and materials for the 2014 academic year. This type of initiative wonderfully strengthens maintaining girls in school and reduces the household vulnerability overall. CCP will try to keep this productive partnership going, although it may have been a one-off opportunity.

**Integrated care (OVC, HBC)**

In this quarter, CCP efforts continued with the MISAU principals supporting the Integrated Caregiver Curriculum through the bureaucratic approval process. [CCP learned that the Curriculum was approved in early January 2014 and is still awaiting the formal letter documenting that approval.]

This integrated care model is the CCP model, which is also the target of the USAID-contracted CCP Mid-Term Evaluation, in process by MEASURE. CCP fully collaborates with MEASURE to provide on the ground support as needed.

**Adherence Support**

Adherence support to build overall treatment retention rates is a continuous key CCP activity, in partnership with the health facilities each CSO refers and is linked to. In some districts, this will be multiple facilities. CCP adherence support includes *busca activa/busca consentida,* as well as individual and family counseling during home visits, and community group based counseling. Collaborative efforts continue with all clinical partners, supported variously by CHASS SMT, CHASS Niassa, Ariel, and CCS. Community collaborations continue with GAACs, PLHIV groups, M2M groups, Treatment Committees, community leaders, etc., to maximize adherence support. Table 8 below shows current quarter results, highlighting the 87% return of defaulters to treatment among those found on the clinics' lost-to-follow-up lists. Efforts continue to resolve problems of initial identity at clinic level, in order to produce more accurate and effective lost-to-follow-up lists in the first place. It is reported that when treatment defaulters do return to their clinics and treatment, they are generally counseled and well received, in some locations due in part to using the *Guia de Referencia* (the referral tool).

***Table 8: Q1-Yr 4 Busca Activa/Consentida by province***

| Province | Lists to CBOs | | | Recovered (found) | | | Recovered (found) and Reintegrated into HU (treatment) | | | % of Recovered & reintegrated to HU against **recovered** | % of Recovered and reintegrated to HU against **list** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **M** | **F** | **TOTAL** | **M** | **F** | **TOTAL** | **M** | **F** | **TOTAL** | | |
| Cabo Delgado | 25 | 49 | 74 | 9 | 11 | 20 | 9 | 11 | 20 | 100% | 27% |
| Inhambane | 27 | 55 | 82 | 7 | 31 | 38 | 5 | 26 | 31 | 82% | 38% |
| Manica | 232 | 349 | 581 | 142 | 231 | 373 | 130 | 225 | 355 | 95% | 61% |
| Maputo | 133 | 203 | 336 | 50 | 83 | 133 | 37 | 61 | 98 | 74% | 29% |
| Niassa | 66 | 99 | 165 | 52 | 77 | 129 | 38 | 64 | 102 | 79% | 62% |
| Sofala | 264 | 451 | 715 | 160 | 272 | 432 | 137 | 236 | 373 | 86% | 52% |
| Tete | 150 | 185 | 335 | 87 | 105 | 192 | 73 | 88 | 161 | 84% | 48% |
| **TOTAL** | **897** | **1,391** | **2,288** | **507** | **810** | **1,317** | **429** | **711** | **1,140** | **87%** | **50%** |

CCP sees different strategies taken in different provinces among the implementing CSOs with their clinical partners. Inhambane and Manica provinces request additional information, such as the name of the community leader where the patient lives.

The new Yr 4 action of an embedded CSO *activista* in the health units to work with the case managers (of USG funded clinical projects) should produce results in the future. The aim of that placement is to increase *busca* effectiveness, and to also increase clinic awareness for referring to the community based services.

Defaulters recovered by CCP *activistas* in CHASS SMT provinces may be affected in ways we do not yet know. An agreement was made that CCP *activistas* would shift their *busca* focus to defaulters who live most distant from the HU since they have bicycles, and leave the defaulters living close to the HU for CHASS SMT *activistas* who do not have bikes.

Niassa province showed the least performance in *busca* this quarter from both analytic perspectives. This is due to three districts - Cuamba, Mandimba and Ngauma – undergoing the finalization of the sub-award process ceasing with the previous "umbrella" organizations and shifting to the community-based associations for implementation. All the *activistas* concerned continued their dedicated service delivery during this quarter, but quite independently during the transition phase. The importance of that continuity cannot be over emphasized as regards uninterrupted care and support for the enrolled beneficiaries.

Maputo province CSOs have improved coordination with the clinics they work with, however the clinic partners had internal difficulties compiling their lists during this quarter, resulting in quite low results. But CCP is taking a pre-counseling approach to discourage defaulting in the first place, utilizing the home visits as a platform for such discussions.

CCP believes that low results in Cabo Delgado province have to do in part to the seasonal relocations of people to their *machambas* (farms) for agricultural activity. The CCP CSO in Pemba district therefore is stepping up community mobilization efforts on adherence to treatment in terms of people informing their location shifts to their treatment clinics.

One summary comment regarding the lower performance shared by Cabo Delgado, Inhambane, and Maputo provinces is the greater challenge of collaboration with the clinical partners at CCP sites there. A seemingly helpful step by these CDC-funded clinics is that they allocated focal persons to collaborate directly with the *activistas* to better accomplish the *busca* activity.

**Pre/Post-Partum Women**

Adherence support among key CCP target groups also continues. Among pre-partum women, 4,737 women were identified and referred to ante-natal consultation in this reporting period. Of this number, per the Performance Indicators on pages 7-8, 276 were referred specifically to MCH services for PMTCT. *Activistas* then followed up with adherence on PMTCT and CCR support to those who had disclosed their status to them.

The CCP implementing CSO in Manhiça district, Maputo province, helped create two new M2M groups in coordination with MCH nurses. These groups started with 19 women each and a third group with 21 women was created in the Manhiça HU. CCP *activistas* counseled the new M2M groups on human rights for HIV positive women,

disclose to their partners for prevention of infection and gaining partner support for adherence, as well as utilizing CCR services and strategies to keep their babies HIV frees.

Another M2M group was created in Marracuene district, **especially to recruit pre-partum women currently in ante-natal consultation.** This new group had 10 such women and 28 *activistas*, which served as an on-the-job-refresher and exchange of experience for the *activistas* on M2M group processes.

To conclude, in general, CCP contribution to M2M meetings includes cooking demonstrations and nutrition education linked to seasonally available local foods. *Activistas* also facilitate discussions with testimonies about stigmatization, and on developing income generation activities. In an **outstanding advance**, in this quarter, two CCP districts – Metarica in Niassa, and Dondo in Sofala province – had M2M group meetings with their male partners participating, inspired by CHASS Niassa's Men to Men groups. CCP plans to first observe the results in these two districts, and then replicate the model if deemed effective and replicable.

**Nutrition Services**

CCP nutrition services continue as from previous quarters, with MUAC applied at the time of family intake to the project, referral to Nutrition Rehabilitation Units where they exist, family nutrition counseling, demonstrating cooking and gardening activities, and referral to SDSMAS and other food resource social services. A total of 6,521 OVC received nutrition services this quarter, per Table 7 above, the majority as actual food provided by INAS, PMA and other local organizations including people of good will. This is unusual and hopefully can be continued as the community structures and services better meet the existing needs. In Table 9 below 3,840 adults, amongst them PLHIV in HBC and PPW, received general CCP nutrition services and referrals. CCP is reporting the 4,737 pre- and post-partum women receiving nutrition services separately, to reflect the importance of that target group.

***Table 9: Nutrition services disaggregated by age and PPPW***

| | Age | | | | |
|---|---|---|---|---|---|
| PROVINCE | 0-14 | 15-17 | 18+ | TOTAL | Pregnant |
| **Cabo Delgado** | 101 | 158 | 270 | **529** | 94 |
| **Inhambane** | 2,518 | 2,381 | 301 | **5,200** | 249 |
| **Manica** | 1,475 | 609 | 1,016 | **3,100** | 2,394 |
| **Maputo** | 553 | 206 | 425 | **1,184** | 823 |
| **Niassa** | 194 | 131 | 329 | **654** | 273 |
| **Sofala** | 983 | 441 | 878 | **2,302** | 762 |
| **Tete** | 189 | 86 | 621 | **896** | 142 |
| **TOTAL** | **6,013** | **4,012** | **3,840** | **13,865** | **4,737** |

Worth noting are the seasonal benefits to nutrition accruing from the rainy season. Home gardens were flourishing, and beneficiaries reported improved nutritional diet and reduced cash spending in the markets. As well, the majority of children were on school holiday and could help the family to make new gardens whose excess produce were sold in local community markets:

*"we're able to collect from our gardens tomatoes, lettuces, green beans, leaves."*

**Partnership for HIV Free Survival (PHFS)**

While funded under FANTA, PHFS is really a Quality Improvement activity, with distinct funds for two years of pilot activities in Dondo district Sofala province, only. During this reporting period, plans were realigned, submitted to URC, and the May 2014 trainings were planned out.

**HBC and Family Health KITs**

During this reporting period, HBC kits procurement processes were initiated for next quarter disbursement according to each provinces scheduled needs to replenish HBC kit contents.

The wrap around service of PSI Family Health Kits remains a robust CCP component. Table 10 shows this period's disbursement, again on a provincial rotating basis dependent on when the provision started. This kit remains the same; *Certeza* water purification product, condoms, soap, and a health education booklet (adult kit). The children's kit includes the same contents, except omitting the condoms. The *Certeza* is replenished monthly.

***Table 10: Health Kits***

| Province | Health Family kits (PSI) | Family kit (INAS) |
|---|---|---|
| Tete | 280 | 27 |
| Inhambane | 400 | 0 |
| Total | 680 | 27 |

On another level, CSO implementing partners in two districts in Tete province were able to provide 27 Family Kits containing: blankets, buckets, mats, soap, small and medium size bowls, cups and pots, specifically for Child Headed OVC households. In coordination with INAS, it was also possible to add on two bars of soap for each family receiving the kit.

*Family Kit distribution in Chiuta and Moatize in Tete province with involvement of community leaders and DPS.*

**Result 2:** Increased family-centered, community-based services that improve health outcomes and quality of life for PLHIV, OVC, and pre/post-partum women and that are

implemented by the coordinated efforts of the Ministry of Women and Social Action (MMAS), the Ministry of Health (MISAU), and civil society organizations (CSOs).

**Activity Area 2.1:** Strengthen the CSOs to assure compliance with MMAS minimum standards for OVC and support the National Action Plan for OVC

In this reporting period, the CSOs strengthened existing Kids Clubs, increased the Kids Clubs frequency and integrated more beneficiary children into the clubs (especially those that in "maintenance" phase).

CSO representatives in Inhambane province participated in a meeting organized by CARE International, with DPS, SDSMAS Maxixe, PLAN International, Samaritan's Purse, SAN and IRD. Together they crafted a plan for nutritional rehabilitation, using the Kid's Clubs as the platform for implementation. Details are yet to be elaborated as regards needs assessment, logistics, where the costs will be borne, etc., but this public-private partnership holds promise for OVC in need of nutritional rehabilitation.

To ensure compliance with the Minimum Standards of Services for OVC, according to the National Action Plan for the Protection of OVCs and children, adolescent and youth, CCP gave a lot of effort to further integrating community leaders in themes related to HIV and AIDS, Gender Based Violence (GBV) and Child Protection in this reporting period.

Tete province saw remarkable results from sensitizing and raising awareness on GBV and child protection, especially protection of girls. In Mavudze Ponte in Chiúta district, the CCP CSO coordinated with the local Police to hold public community meetings on these topics.

*Participation of community leaders, religious leaders, and Police officials in the Tete province community meetings.*

As a result of these discussion meetings, the district Police banned the projection of pornographic films previously shown in the barracks for Mavudzi Ponte residents regardless of viewer age. The Police also ordered opening and closing times for barracks that are frequented by children under 15 years of age.

In November, CCP supported a senior MMAS technical officer to participate in the REPSSI International Conference in Nairobi, where CCP's abstract on its holistic approach to OVC care and support was selected for oral presentation. In fact, this presentation was chosen to open the topic on the first day of the conference.

CCP Technical Officers also participated in a high level NUMCOV meeting, attended by 70 participants including members of the central OVC TWG, DPMAS (provincial) directors, OVC focal points, and other NGOs implementing OVC activities. The OVC TWG presented its activities carried out in 2013; participants shared experiences on children protection at various levels and identified priorities for 2014, one of which is to intensify creation of CCPCs. Preparations for the regional workshops in January 2014 to disseminate the Minimum Standards of Services for Children were made, the CCP-produced Child Visit Protocol was presented, as well as the Terms of Reference to elaborate the MMAS social letter for services.

Moving to Moamba district in Maputo province, the CCP OVC TO showed UNICEF produced child protection films about child protection in Kids Clubs. She facilitated follow-up discussions on the film and focusing on Child Rights in Mozambique. The film viewers were also sensitized on child trafficking, since unfortunately this practice has increased in frequency in Moamba. In fact, Moamba is just the example of broad distribution of the UNICEF video to all CCP CSOs in Maputo, Inhambane, Sofala, Tete, and Cabo Delgado provinces in this quarter. Niassa and Manica provinces will be covered in the next reporting period.

In Tete province OVC care and support activities in this quarter focused mainly on:

- Pediatric health and ART in coordination with CHASS SMT; community counseling and testing, family based sensitization for child and PPPW HIV testing/screening. A total of 767 were tested, 369 male and 398 female, of whom 45 males and 65 females tested positive, inclusive of adults and children.
- Talks to M2M groups by CCP CSOs with SDSMAS/MCH on pre-natal consultation; community mobilization on mother child and school health including adolescents, in coordination with UNICEF in Cahora Bassa and Changara districts;
- Developing the integration of youth for vocational training. An opportunity was found in Angónia district for four male OVC between 15 – 17 years old with a workshop (Garage) for auto services, painting and panel beating;
- VS&L groups; youth above 15 years old in savings groups, 43 total in three districts alone.

  The salient feature generally of this age group is either the frequency in which they are under guardianship of their aged grandmothers who are usually past the income producing phase of their lives, or they are the child head of their household.
- Kids Clubs; 45 new clubs were created across the province with 1,041 children between 6 and 17 years old. The clubs are frequently held on Saturdays, in some districts they use school yards/premises, others meet under the trees in the community centers. Consistent with the other clubs associated with CCP, main activities include: support school age children with their home work; discuss themes related to child rights and duties according to legislation in place, oral hygiene, dancing, sewing, soccer, cooking demonstrations for OVC between 12 and 17 years (while open to both girls and boys usually only girls take this up), and family planning (FP) in coordination with the MCH focal point.

In Chiúta district in Tete province, we can see the community level linkages maturing as an M2M group facilitated various cooking demonstrations in Kids Clubs, to show the necessity of self-care, food, and personal hygiene, and how important it is to combine these components for good health and nutrition. The caregivers themselves are the ones doing the cooking, mobilizing the children to participate, and sharing the cooked foods with the children.

*Cooking demonstration for children in Kids Clubs by M2M group members, Chiuta,Tete.*

Noted both above and below, the creation of new Kids Clubs greatly benefitted from the seasonality of school vacation in this reporting period. Now joined in, participating in the clubs will help to support and balance children's lives as they go forward into the next school year. The activities in the clubs and the personal attention for the children participating comprise aspects of psychosocial support, as well as support with homework during the school going terms. The *activistas* made extra effort to explain to caregivers the importance of participating in the Children Clubs.

***Table 11: Q1 Yr 4 Kids Clubs created, per province disaggregated by gender***

| **Provinces** | **Previous total number of Clubs** | **# of kids clubs created in Q1 Yr4 Children** | **Total Cumulative number of Kids Clubs through Q1 Yr 4** | **Children disaggre-gated by gender** | | ***Total children participated in new Kids Clubs*** |
|---|---|---|---|---|---|---|
| | | | | **M** | **F** | |
| C. Delgado | | | | | | |
| Manica | | | | | | |
| Niassa | | | | | | |
| Sofala | | 44 | | 793 | 693 | 1,486 |
| Tete | | **45** | | 495 | 546 | 1,041 |
| Maputo | | **07** | | 40 | 20 | 60 |
| Inhambane | | **11** | | 429 | 537 | 966 |
| **Total** | | **107** | | **1,757** | **1,796** | **3,553** |

*Children from two different Kids Clubs of the same community are teaching one another to make toy cars using clay. The activista uses this opportunity for individual conversations with both the girls and the boys.*

In Pemba, Cabo Delgado province, the CSO partner Kaeria established a cross-clubs mixed soccer team including 24 females and 41 males. The team was invited to play in the provincial soccer championship, and news of this has motivated many children to enroll themselves and participate in the kids clubs.

Nine (9) CCPCs were created in the districts shown in Table 16 - Committees, of which three (3) were created and certified by DPMAS in Maravia, Zumbo and Magoé districts in Tete province. CCP technical team provide support. In Matutuine district in Maputo province, three new CCPCs were created, facilitated by SDSMAS, community leaders and the CCP OVC technical officer. A CCPC was also created in Ngauma district in Niassa province, facilitated by the SDSMAS Social Action technicians and the CCP CSO.

Q1 Yr4 has been very productive in a number of OVC activity areas, especially in the areas less affected by the political military violence around the elections.

**Activity Area 2.2:** Partnerships and linkages are used to ensure OVC Services are comprehensive and accessible

Partnerships and linkages in the CCP implementation areas very considerably, as they are very localized. In Mandimba district, Niassa province, coordination meetings were held between the staff of Irmãos Unidos and Radio Televisão Rural, which resulted in inviting 10 children of both genders, to participant in children programs launched by the Radio. These children had the opportunity to talk about the gains of CCP and Child Rights and duties. Also in Niassa province, in Cuamba district the CSO established a partnership with the Municipal Council to provide support for CCP beneficiary children in the form of school materials to be distributed in Kids Clubs as a way to motivate participation of more children and caregivers.

In Sofala province, CCP strengthened the partnerships with the CAP supported Programa para o Futuro (training on computer skills) and Aldeia das Crianças (SOS Village) (youth vocational training). As a result a total of 33 youth (17 male and 16

female) were graduated with either Computer Literacy, Social Communication, Culinary, Hairdressing, Plumbing, or Sewing skills.

In Manhiça district in Maputo Province, in coordination with SDSMAS and the SMI (MCH) Health Unit department, three trainings were conducted on Sexual Reproductive Health and Family Planning, over three days. Two MCH nurses from the HU conducted this training for 80 CCP beneficiary family member adolescents (45 Male and 35 Female). Other participants included community leaders, HU technicians. Again, CCP believes in the long term community viability of current project activity focuses; health system personnel conducting such trainings helps to establish clinic-community partnership and ownership of local concerns.

Topics included sexuality and reproductive health, going out, love and pleasure, reproduction, contraceptives and family planning, risks of early pregnancy and premature marriage, abortion, use of condoms and advantages of avoiding sexual intercourse (abstinence).

**Result 3:** Increased number of HIV/AIDS positive individuals and affected households has adequate assets to absorb the shocks brought on by chronic illness.

**Activity Area 3.1:** Increase access to skills building and household economic strengthening opportunities to improve the wellbeing of all target groups

During this reporting period Project HOPE and its partners created 75 new VS&L groups across the seven (7) CCP provinces with a total of 1,404 new members (375 male and 1,302 female), slightly exceeding their quarterly target.

Project HOPE held trainings for CSO supervisors and M&E officers in Maputo and Niassa provinces. This training *(1)* created an opportunity for participants to improve their understanding of the integrated services and the need to maximize referral and integration of OVC, PLHIV caregivers and PPPW in the VS&Ls, *(2)* improved the knowledge of "Community Facilitators" (of the VS&L groups) about the CCP integrated approach and the CSO supervisors' knowledge about the economic strengthening component, *(3)* included SDAE technical officers thereby creating an opportunity for direct technical assistance for income generating activities related to VS&Ls.

***Table 12: Q1 Yr 4 VS&L groups disaggregated by gender***

| Provinces | Global Targets | | | | Nº of cumulative groups | | | | New entries in the quarter | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # of groups | # of beneficiaries | | | # of groups | # of beneficiaries | | | # of groups | # of beneficiaries | | |
| | | M | F | T | | M | F | T | | M | F | T |
| **Maputo** | 35 | 210 | 490 | 700 | 55 | 245 | 834 | 1079 | 2 | 9 | 28 | 37 |
| **Inhambane** | 70 | 420 | 980 | 1400 | 105 | 331 | 1,965 | 2296 | 20 | 85 | 311 | 396 |
| **Sofala** | 182 | 1080 | 2560 | 3640 | 222 | 1427 | 2821 | 4248 | 19 | 88 | 324 | 412 |
| **Maníca** | 140 | 840 | 1960 | 2800 | 128 | 960 | 1,999 | 2959 | 4 | 37 | 46 | 83 |
| **Tete** | 182 | 1080 | 2560 | 3640 | 145 | 766 | 1408 | 2174 | 28 | 135 | 309 | 444 |
| **Niassa** | 70 | 420 | 980 | 1400 | 57 | 263 | 440 | 703 | 1 | 3 | 11 | 14 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cabo Delgado** | 10 | 84 | 196 | 280 | 11 | 79 | 204 | 283 | 1 | 0 | 18 | 18 |
| **Total** | **689** | **4,134** | **9,726** | **13,860** | **723** | **4,071** | **9,671** | **13,742** | **75** | **357** | **1,044** | **1,404** |

Interestingly, what appears to be low performance in Maputo province, is not. The target for creating VS&L groups had already been exceeded in that province. This is also true for Cabo Delgado province but not as dramatically. The low performance in Niassa is real, predicated by making a difficult transition from a PH HES CSO for that province who did not perform well, to PH for its direct implementation.

Many groups created in Yr 3 continued, and established linkages with micro finance institutions (IMF), for example a group from Cuamba with 30 members which linked itself to (BCI) International Commercial Bank has already deposited 115.050,00 MT in the bank.

In seven project districts in Sofala province specifically, some groups have established linkages with BOM, BCI, Procredit and other finance institutions as Table 13 below shows. Using actual banks where they are available, represents greater security for VS&L group funds as they increase in volume. These linkages can be a bit challenging to fully understand, as the first step is the VS&L group gets linked to the institution and serves as a reference. Then, often a group member applies for and qualifies for a bank loan, then the group itself follows by opening a solidarity account in the name of some members. Even though the group is linked, not all the group members are guaranteed to qualify for a bank loan per that bank's criteria.

***Table 13: VS&Ls linked to financial institutions in SOFALA***

| District | # of Members | Groups | Total Amount | Financial Institution |
|---|---|---|---|---|
| Caia | 8 | 6 | 45.700 | Consorcio/STANDARD BANK |
| Marromeu | 30 | 5 | 60.500 | CONSORCIO/Barclays |
| Gorongosa | 5 | 2 | 20.000 | BIM |
| Beira | 18 | 2 | 28.750 | BIM, PROCREDITO and BOM |
| Dondo | 15 | 1 | 45.930 | BOM, BIM and BCI |
| Buzi | 8 | 1 | 65.350 | BIM |
| Nhamatanda | 48 | 8 | 165.715 | BOM and BCI |

Similarly developing in Inhambane province, two VS&Ls have opened Mkesh accounts facilitated, by German Cooperation Agency through the partnership with Kukula. A group with 25 members deposited 72,800,00 Mt, while another group with 25 members deposited 23,150,00 Mt also into Mkesh accounts. Mkesh allows those account holders to access and manage their funds through their cell phones. GIZ is working with the PH HES CSO ADEM in Sofala province to achieve this same service.

Some 104 VS&L groups across the project have created and are implementing a social fund to support OVC. LIWONINGO in Maxixe district in Inhambane province is a special case. One VS&L group there, partnered with a local GRM entity, and deposited 5,630,00 MT (almost $200) at the end of the savings cycle in the INAS

account to support OVC. This social fund money will be supporting the INAS initiative for providing school uniforms and materials, and transportation for children in the next school year starting next quarter.

In Tete province a VS&L group in Tsangano district provided support to 20 OVC drawn from 12 families, and 10 elderly adult caregivers using the social fund. They gave basic needs products, such as soap and food.

The VS&L strategy has helped many members to improve their living conditions, by rehabilitating their habitations, paying their children's school costs, increasing the volume of their business, including their farming and garden area. As an example, Ms Amelia has established her business and opened a tuck-shop where she sells fresh products and even bought a freezer as a result of her participation in the VS&L group.

*Amélia, shown in her tuck-shop. She is a fabulous example of the integrated nature of CCP, the continuum of care, adherence to treatment, and returning to life. She entered the VS&L group as a PLHIV CCP beneficiary. She took a loan and invested in her tuck-shop right in her back yard, and repaid the loan. After a year of savings in the second cycle that started in March of 2013, Amelia's saving amount was 800 MT per month and she took a loan of 1500 MT. In the following month she returned the loan with interest. Currently Amelia's savings are at 10,700.00 MT and her business has diversified to also selling crates of tomatoes and some fresh drinks. She has improved to a "fixed" situation where she sells basic needs products, and her own diet has improved significantly. She has three meals daily, pays for her child's school needs, has electricity in her house and the tuck-shop, has bought a bicycle which she uses to go and buy merchandize and also to go the HU to collect her ARVs. She feels that her socio-economic life has improved significantly since she joined the VS&L group and contributes to her good adherence.*

Such a living example serves as community mobilization in itself, often resulting in an increase of VS&Ls membership. When CCP was starting the VS&Ls, many beneficiaries did not want to join because they felt they would be marked as being PLHIV (and discriminated against). This challenge was overcome because many groups are mixed, composed of PLHIV, various caregivers and pregnant women.

The holistic nature of CCP implementation improved even more because of the increasing collaboration between *activistas* and Community Facilitators (of the VS&Ls); they carry out joint planning sessions, joint visits, which are also simultaneously carried out with members of the consortium (FHI 360, WR, Africare and Project HOPE). These

linkages have greatly increased VS&L group awareness and mobilization in all communities where the program is implemented. Offering the opportunity to PLHIV in GAACs to form or join VS&Ls is still in early stages; they do not exist in all the CCP districts and are sometimes not very open or visible when they do.

***Table 14: VS&L Group composition per province, disaggregated by member type***

| Province | Nr of Groups | Activistas | Caregivers | PLHIV | GAACs | CC | M2M | Community members | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Maputo** | 55 | 107 | 107 | 378 | 0 | 15 | 43 | 380 | **1,079** |
| **Inhambane** | 105 | 122 | 102 | 131 | 0 | 27 | 151 | 1,763 | **2,296** |
| **Sofala** | 222 | 516 | 514 | 1183 | 108 | 56 | 553 | 1,318 | **4,248** |
| **Manica** | 128 | 226 | 508 | 626 | 5 | 11 | 106 | 1,490 | **2,959** |
| **Tete** | 145 | 190 | 216 | 156 | 28 | 43 | 61 | 1480 | **2,174** |
| **Niassa** | 57 | 24 | 119 | 129 | 1 | 4 | 4 | 422 | **703** |
| **Cabo Delgado** | 11 | 12 | 18 | 25 | 0 | 15 | 20 | 193 | **283** |
| **Total** | **723** | **1,197** | **1,584** | **1,624** | **142** | **177** | **938** | **6,342** | **13,742** |

Interestingly, the vast majority of *activistas* themselves are in VS&Ls, which accomplishes a number of project benefits. First, they are modeling the strategy and thus can better recommend CCP beneficiary households to join. Second, many CCP *activistas* are PLHIV themselves. Third, taking their personal savings experience to a logical conclusion, they can be encouraged to form VS&Ls to support continuing community-based services provision after this project concludes.
At this point the 1,584 "caregivers" members of the VS&Ls have not been translated into Economic support for OVC. CCP-Project HOPE is still working on verifying and finalizing that data point.

***Table 15: Q1 Yr 4 VS&L Groups Amount Saved in Meticais***

| | Province | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **VS&L relevant data** | **Maputo** | **I´bane** | **Sofala** | **Maníca** | **Tete** | **Niassa** | **Cabo Delgado** | **TOTAL** |
| Total savings | 1,666,574,00 | 1.663.553,00 | 3.856.242,00 | 5.261.768,00 | 1.107.934,00 | 9.032,00 | 358.735,00 | 12,423,838,00 |
| Total fine | 885 | 112.028,00 | NA | 22.549,00 | 5.000,00 | 38 | 280 | 140,780,00 |
| Total social fund | 136,045,00 | 127.412,00 | 120.324,00 | 336.346,00 | 53.698,00 | 1.194,00 | 12.710,00 | 787,729,00 |
| Total interests from loans | 281,432,00 | 277.473,00 | 886.453,00 | 1.250.766,00 | 205.097,00 | 10.264,00 | 23.550,00 | 2,935,035,00 |
| Total income (1+2+4) | 1,381,611,00 | 2.180.466,00 | 886.453,00 | 5.892.789,00 | 1.133.855,00 | N/D | 393.720,00 | 11,868,894,00 |
| Total disbursed loans | 1,331,257,00 | 416.453,00 | 4.540.502,50 | 4.471.826,00 | 1.324.968,00 | 9.000,00 | 31.160,00 | 12,125,166,00 |
| Total reimbursed loans | 676,810,00 | 1.249.360,00 | NA | 3.493.186,00 | 626.821,50 | 0 | 63.200,00 | 6,109,377,50 |
| Total outstanding loans | 573,522 | 1.249.360,00 | 17.402,00 | 2.447.986,00 | 1.663.840,50 | 9.000,00 | 500 | 5,961,610,50 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| TOTAL – value in cash box (at the end of savings, reimbursements and disbursements) | 1,284,528 | 2.885.961,00 | 202.192 | 5.892.789,00 | 414.390,50 | 1.264,00 | 796.520,00 | 11,477,644,50 |

*A majority women VS&L group in Marracuene district, Maputo province, in action during the Share Out at the end of a savings cycle. Women are always the majority members in the VS&Ls, and as they progress to income generating activities, their vulnerability decreases, as well as for their children.*

## Cross Cutting Activities

**Activity Area 4.1:** Community mobilization

- In context of coordination and cooperation with MMAS and MISAU, meetings were held to evaluate the activities according to the project MoUs. Both ministry partners requested that the FHI 360 quarterly reports regularly sent to GRM entities such as the provincial governor, DPS, DPMAS, the Nucleo Provincial, also be sent to their Department of Planning and Cooperation.

- In Maxixe in Inhambane province, the *activistas* with the community leaders visited 11 sub-communities where they sensitized on voluntary testing, adherence to treatment (ART and TB), and joining VS&L groups and investment into small scale IGAs.

- Generally, in all CCP provinces the CSOs participated in December 1 (World AIDS Day) activities through health campaigns and fairs. They used the day to lead discussions on testing, living positively with HIV, and improving their diet, as well as malaria prevention, water treatment, TB treatment and accessing family planning.

- Boane district in Maputo province was able to overcome reluctance to test young children for HIV through a mobile brigade organized in collaboration with the *activistas* and the HU, who then tested 28 people in a family testing scenario. Manhiça district tested 70 in the same approach.

- International Girls Day was commemorated in all 52 districts of CCP, where messages of education, protection of girls, prevention of early pregnancy and premature marriages were disseminated. Primary schools were frequent sites for the commemorations, led by school directorates, the partner CSOs, SDSMASs, with CCP supporting the CSOs. In addition to a single day commemoration to achieve special community wide sensitization, these education messages are a regular component of talks given in children's clubs and during home visits. Again, working together in partnership with the local structures such as the teachers, community leaders, local police, and Social Action focal points, builds local capacity to carry on activities in the future.

  Commemorations often had the children organized in small groups where they held discussions after the speech on: the importance of girls' education, family planning, pregnancy and premature marriage, gender based violence, sexual abuse and child trafficking. The children themselves had the opportunity to present songs and dancing.

*Community Leader distributing materials to girls*

- CCP and CHASS SMT jointly carried out an activity in Dondo district in Sofala province to join in the 16 Days of Activism Against Sexual Violence campaign, running from November 25 to December 10th. The resulting Health Fair provided the participants involved in fighting against gender based violence to raise awareness in the community about this problem which hugely interferes negatively on the life of the community. It was also an opportunity to observe equity rights between men and women.

The Health Fair included aerobic exercise, nutrition education and cooking demonstrations, nutrition status screening using the MUAC, evaluation of blood pressure and counseling for HIV testing. As a new slant on things, the majority of cooking demonstrations were carried out by men, as a way to encourage other men to support on domestic activities.

Speeches covered PMTCT, MCH, violence and sexual abuse, domestic violence and how women and children can find help. Men were sensitized to participate actively on family health promotion activities and other ways to promote family well-being. The report is currently in Portuguese but is being translated into English particularly for inclusion in the SAPR, per request.

**PLHIV Support groups**

As in other quarters, *activistas* continued to create new PLHIV support groups, although not quite successful in some communities and HUs because people sometimes feel they already spend much time in line for consultation or to collect their ARVs. *Activistas* assist with these groups as part of the post-discharge adherence support they provide for PLHIV.

In Manica and Sofala provinces, the DPS held a meeting with the NGO forum to define alternative strategies to support the communities affected by the political military tension and violence. During this quarter there is increased movement as people try to determine where is safest to be, and there is fear that the number of defaulters may increase. A request was made for CCP supported *activistas* to extend their support to GAACs and other PLHIV groups, to best maintain adherence in spite of the difficulties.

***Table 16: Q1 Yr 4 Committees and Groups Created, disaggregated by sex***

| **Provinces** | **A CLC** | | **B CCPC** | | C M2M | | **D PLHIV** | | **E CCGS** | | **F Treatment groups** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** |
| Sofala | **36** | **27** | **133** | **109** | **155** | **0** | **103** | **85** | **28** | **26** | **72** | **64** |
| Maputo | 0 | 0 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 10 | 0 |
| Tete | 66 | 49 | 258 | 214 | 313 | 0 | 205 | 168 | 49 | 44 | 148 | 124 |
| Inhambane | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Manica | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cabo Delgado | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Niassa | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **102** | **76** | **391** | **323** | **478** | **0** | **308** | **253** | **77** | **70** | **230** | **188** |

A=Community Leader Councils
B=Community Child Protection Committees
C=Mother to Mother Groups
D=People Living with HIV (positive living groups)
E=Youth Health Action Committees
F=ARVs treatment groups

In Tete, 20 of the 204 M2M groups are in the graduation phase. This means they have been determined by the Health Unit that formed them to be strong enough to take leadership roles in the community. In this scenario, each member of the M2M group may start an M2M group in the area where she resides, and will be supported by CCP *activistas*, which also frees the HU to start new M2M groups.

Another type of small group comprised of youth and adolescents conduct voluntary speeches in the communities and have musical and theater activities that present sensitization on HIV preventions, and, are linked to community radio. These groups are found in Chiúta, Mutarara and Zumbo districts in Tete province, and represented as CCGS in the table above.

**Coordination meetings**

For this reporting period, CCP highlights the NGOs Forum meeting in Tete in which the FHI 360 Provincial Coordinator was recruited to participate. NGOs Forum outputs included mapping of district partners; and improving coordination, and redefining, of the referral system. The second meeting was held with NPCS, where the district focal points were introduced and December 1st (World AIDS Day) commemorative activities were evaluated, as well as a male circumcision campaign conducted by PSI.

In Pemba, Cabo Delgado, three meetings were held with Ariel (the non-USAID funded clinical partner), to strengthen partnership coordination and responsibilities of Ariel Health Unit focal points. Improvement is needed in order to overcome challenges that *activistas* face to find the proper contact person for the clinical partner.

**Care and support to *activistas***

In this context, all the CSOs *activistas* continue to receive technical support from their supervisors and the CCP team, to improve their knowledge regarding all project components. As mentioned above, their participation in VS&Ls which improves their own lives, also serves to model that self-care approach to others. Many CCP *activistas* also have their own income generating activities, stemming from their VS&L participation, which helps to support their own families or households.

Currently, it can also be noted that the behavior of *activistas* and the CSOs staff, reveals strong team work and understanding the CCP integrated approach, including interpersonal and psychosocial support for the on-the-ground caregivers, the *activista*s.

**Skills transfer to families to take care of OVC and PLHIV**

The two greatest challenges for PLHIV, PMTCT, and OVC families seem to be lack of financial management skills and lack of parenting skills. CCP is addressing both gap areas with the VS&L groups and piggy backing on with Financial Literacy training, and with developing Parenting Skills sessions, to be rolled out in the next implementation period. Many relevant curricula have been reviewed, the structure of delivering the skills sessions will be the VS&L groups themselves, as well as using the Children's Clubs as a second platform to gather parents and guardians for learning.

**Activity Area 5.1: Program Management**

**Staffing:**
Maputo: Ms Sandra Vubelane, CCP Technical Officer for Nutrition, PMTCT, and Gender, relocated with her family to Beira, Sofala Province during this reporting period. She now sits in the FHI 360 Sofala province office, while still maintaining her role as

"central" technical team. This shift has the added benefit of her being at ready access to the PHFS pilot area, Dondo district, for which CCP is the designated community partner for that province.

**USAID visits:**

Boane district received a visit from USAID and OGAC officers (USA and Mozambique). This visit especially provided the opportunity for the CHASS SMT AOR to learn CCP implementation at community level first-hand, to better understand both the successes and challenges of the referral "linkages" between the community and clinical projects. Ms. Funni Adesanya from the Office of the US Global AIDS Coordinator joined a representative of Project HOPE, the CCP Technical Director and Community Mobilization Officer, the CSO coordinator and Supervisor. The visitors had a comprehensive program which included meeting with the local government representative at SDSMAS, visiting the hospital where CCP beneficiaries are referred, interacting with the Kids Clubs, visiting a HBC patient and lastly visiting a VS&L group which was Closing its Cycle. The visitors had an opportunity to hear directly from CCP beneficiaries and the VS&L members about the benefits and experience gained from being involved in CCP. Valuable observations and recommendations included more attention to pediatric AIDS cases and accessing community HIV testing.

**Year 4:**

The CCP Yr 4 Workplan (narrative and matrix), Budget, M&E Plan, and PMP were approved in December of this reporting period.

**Subcontracts:**

FHI 360 practices both financial capacity building, and compliance monitoring, with its sub-contractees. In its role to assure compliance with rules and regulations, FHI 360 practices Financial Site Visits (FSV) to those CSOs with whom it sub-grants. In the case of CCP, the Grant Under Contract (GUC) method is used to fund the CSOs. Following up earlier FSVs, it became clear that two CSOs implementing CCP were not responding correctly to a few queries which had arisen. All efforts were made to both avoid any risk to the donor funds as well as to preserve the GUC and implementing relationship. The two CSOs' GUCs, however, will not be renewed. FHI 360 will complete the close out of these two CSOs, endeavoring to transfer all project assets especially the beneficiaries, activistas, all files and data, etc., to replacement CSOs to continue implementation in the five subject districts: Matutuine and Moamba in Maputo province, and Changara, Marávia, and Mutarara in Tete province. CCP has analyzed the situation and believes approvable replacement CSOs exist in Maputo province, but far less likely in Tete province. In the original public tendering process, it was very challenging to find viable CSOs for some of the districts. [CCP is analyzing now for shifting project efforts to either Acceleration Plan districts in Tete province if any viable CSOs are operating there, or shift the funds to Acceleration Plan districts in Manica or Sofala provinces.] Regardless, all GUC development will follow the protocols in the approved manual.

**Funding Modifications:**

Incremental funding per Modification 4 was received on October 18, with gratitude, after coming close again to ceasing implementation. The repeated incremental funding scenario creates two sides of undue burden on CCP. First, critical project management effort gets diverted to administrative tasks, which have a long term effect. For example, with only partial funding, the strategic partner subcontracts and GUCs

must be only partially funded. In CCP, there are three INGO subcontracts who fund a further total of 19 GUCs, currently two Mozambican NGO subcontracts, and 30-some GUCs directly under FHI 360. Funding to all these implementing partners then requires, at minimum, two complete rounds of subcontracting or sub-granting in a project year, depending on the number of donor Modifications. This gobbles up enormous staff time and resources.

The even more problematic side of the incremental funding scenario is the effect on the subcontracting partners and implementing CSOs. An environment of uncertainty cannot help but arise. FHI 360 policies and procedures require processing and paperwork as well, to understand possible funding gaps and protect against risk. Without the donor funds flowing in per award expectation, projects ultimately need to cease operations, since projects cannot obligate to others what has not been obligated to themselves. The up and down nature of running out of project funds while awaiting donor funds translates to loss of morale among all levels of the project, from the Maputo central management and technical team, to the provincial teams of both FHI and its INGO strategic partners, to the CSOs and community level implementers who actually carry out the vital work of this project. Somehow CCP has been lucky so far to not suffer staff attrition, but if incremental funding becomes the normal way of doing business, it will be extra challenging to keep all the human resources in place at all the project levels. Momentum and confidence lost require double effort to resume.

Lastly but most importantly, funding gaps yield implementation gaps. Tens of thousands of beneficiaries stand to have services delivery or support interrupted or stopped altogether. Building individual adherence and community level retention rates suffer with funding gaps, meaning PLHIV, OVC, PPPW, and their communities are at stake.

The PHFS funds for the two years of activities were included in the October Modification 4. During this quarter, much groundwork has been carried out between the community and clinical partners in the pilot program, with URC, FANTA, and the other PHFS partners. One result of this funding in this quarter was the shared activity between CCP (PHFS community partner) and CHASS SMT (PHFS clinical partner) in Dondo, marking the 16 Days of Activism campaign in December.

**M&E:**

As mentioned earlier in this report under trainings, FHI 360 conducted DQA training (ToT) in Beira for its M&E Technical Officers (across projects), including the Africare Manica province M&E officer. All these M&E staff will then cascade the DQA methodologies and practices to the CSOs M&E people, as part of an ongoing systematic effort to improve the quality of FHI 360 data. Additional outcomes from this large effort would be increased understanding of community level staff on data quality and reporting as well.

### Activity Area 5.2: Collaboration and partnership

To ensure coordination and collaboration, meetings with partners were held across the project with MISAU, MMAS, ANEMO, SDSMAS, DPS, DPMAS, Comité TARV, NPS, GAVV, INAS, Community Leaders, CHASS SMT and Niassa, TB CARE, ROADS, PATH, ADELT, REDE CAME, ICDP, FANTA, CAP, and ADEM, as well as with strategic partners Africare, Project HOPE, and World Relief.

While many issues discussed remain the same from quarter to quarter but with deepening the discussions, or acknowledging new aspects, the additional topic during this reporting period was SECURITY, see next section.

Participation in primarily GRM technical working groups remains a high priority, and CCP technical team members are well regarded for their participation and contributions. MMAS seems especially appreciative of the leadership by CCP in OVC care and support work.

CCP *activistas* continue collaborating with Health Units and existing social services in the community to strengthen referral linkages for enrolled project family members. Across the project, 11,464 were referred to clinical and social services in this reporting period (Table 2). This total represents all areas of referrals in the project.

While the number and sampling of variety of meetings are shown in this report, the real significance is the actual working together with government, civil society, international NGOs, Mozambican NGOs, other projects, like-minded collaborators – all to achieve improvement in the quality of life of Mozambicans and to continuously build capacity at the community, district, and project team levels.

**Major Implementation Issues**

- The growing military political tensions and violent actions during the reporting period were creating worrying insecurity and risks to human well-being in certain implementing areas. People in affected districts suffer fear, constraints on their mobility and activities, reduced access to clinical and social services. The first concern is and must be people's safety. Obviously this has impact on project implementation and results, on top of the potential negative human toll. Security alerts and travel ban directives also keep project staff from carrying out their TA and support activities, further isolating the implementing partners in highly affected areas. CCP attempted a documentation table of affected areas of political military violence during the municipal elections period. See second Annex. While a first attempt, it does give a picture to appreciate in terms of project implementation, data collection, etc. FHI 360 monitored the affected areas as closely as possible, benefitting much from provincial level teams who could either uphold or dispel rumors, and issued travel advisories as needed. With presidential elections planned for 2014, we all must accept that security based interruptions may become normal occurrences and develop mitigation strategies as possible.

- Incremental funding transitions result in challenging periods of slowing down, uncertainty, and demotivation as discussed above under Funding Modifications.

**Collaboration with other donor projects**
This topic is well covered throughout this report.

**Upcoming Plans for Q2 Yr 4 (regular activities throughout the quarter, but all dependent on next Modification)**

- CSO supervisors and CCP staff to replicate supportive supervision training
- Reinforce the component of financial literacy and entrepreneurial skills

- Conduct Refresher training to CSOs in the direct implementation areas (Niassa, Maputo and Cabo Delgado)
- Identify, where possible, market opportunities to create economically viable participation of private sector in promoting financial literacy and other economic activities extending services to target communities
- Link existing VS&L groups to MFIs for more formal financial services
- ADEM to continue Organizational Capacity Building in their target districts
- CCP TOs to continue Coaching of previously CAP strengthened CSOs
- Support MEASURE evaluation of mHealth mobile *busca activa* pilot in Sofala Province, with selection of *activistas* to receive mobile phones
- Support MEASURE evaluation of Integrated Caregiver model as needed
- Finance Team continue systematic Financial Site Visits to CCP CSOs, to monitor financial performance and compliance
- Commence on-the-job training model of refresher trainings

January 2014 specifics:
-CCP M&E participate in MISAU HBC indicators development process
-ADEM Org Cap Bldg CSO assessments
-Develop abstract with Project HOPE for IAS 2014 submission
-FHI 360 Internal Audit (2 weeks); meetings, Compliance Training
-Support ASPIRES HES assessment activity in Mozambique
-CCP OVC Tech Offcr participate in MMAS regional dissemination mtg (Minimum Package of Services for Children)
-Activate Limitation of Funds Notification process re Funding Modification
-CCP contribute to all relevant GRM quarterly provincial rpts; FHI 360 Moz annual rpt

February 2014 specifics:
-Participate in ASPIRES HES assessment as individual informant
-Host USA Ambassador visit to Pemba district partner Kaeria
-Support MEASURE *Busca Activa* feasibility pilot costing component
-CCP Tete participate in Vale Social Responsibility workshop
-Conclude staff performance evaluations
-FHI 360 Security Team visit

March 2014 specifics:
-Share hosting of US Ambassador visit to Tete province
-CCP COP to serve as Acting Country Director during CD absence to FHI 360 GLM
-Begin preparations for SAPR

**Evaluation/Assessment Update -**

| Underway during the reporting period: | |
|---|---|
| | |
| Study 1:<br>Feasibility Study of mHealth application in *busca activa* activity pilot, MEASURE Evaluation contracted by USAID.<br>Selected CCP *activistas* will be provided cell phones and training to use them for receiving the treatment defaulter lists from the clinics and reporting back, in collaboration with CHASS SMT clinic Case Managers from the clinic side. CHASS SMT has contracted with Dimagi as the technical provider. The cell phones are intended to replace the paper based and more time consuming travel to and from the clinics to carry out this regular activity. Study site is Munhava clinic area in Beira. CCP and CHASS SMT both are pleased with this additional opportunity to partner closely. All the involved parties based in the US and Mozambique hold bi weekly | |

progress meetings, by teleconference or email.
Initial training has taken place, the MEASURE timeline is still to complete the eval of the pilot by end April 2014.

Study 2:
Integrated Caregiver Model Evaluation.
MEASURE again contracted by USAID, hired a Mozambican study coordinator, the evaluation protocol is well developed and has been submitted for IRB approval. Study sites have been selected. Data collection was set for first two weeks in February, next quarter.

**Success Stories, photos***:*
A success story is annexed, as well as excerpts being included within this report.

**Financial Information:**
Q1 Yr 4 Pipeline Report is attached as the first Annex.